Chronic Health Consultation Form

For health consultations, please fill out the following form and send it by email to: kelsey@myallforjesus.com When filling out the form, please be as specific and detailed as possible. The more information you share the easier it will be to offer you assistance. All information provided will be kept confidential and contact information will not be shared or passed on to other parties.

1) Contact Information

First Name: _____ Last Name: _____

Email: _____ Phone Number: _____

2) Client's Personal Information

Name of Client: _____ *(if different from above)*

Age: _____ Height: _____ Weight: _____ ☐ lbs/oz ☐ kg

Gender: Male ☐ Female ☐

Ethnic Group: _____ *(some health conditions are relative to race and family heritage)*

If you are submitting this form on behalf of another person, what is your relation to the client?

_____

Marital status? ☐ Single ☐ Married ☐ Divorced / Separated ☐ Widowed

If you are currently in a relationship, how would you describe it?

_____

3) Referral

Who referred you to us, or how did you hear about us?

_____

4) Current Health Concern

What is the nature of your chronic health condition?

When did you first develop symptoms or first realize you had this condition?

How long have you had this condition?

Do you have any medical diagnosis of your condition?
(if yes, please specify what the diagnosis is and who it was that gave the diagnosis)

Are you currently taking anything for this condition?
(medicines, pain killers, homeopathic treatments, nutritional supplements, etc.)

Have you tried any other treatments in the past? If so, what have you tried and what was the outcome?

Do you have any known allergies? *(medicine, foods, chemicals, etc.)*

Please list all medications and supplements you take on a *regular* basis:
(including standard and traditional medicines, homeopathic treatments, herbal or nutritional supplements, etc.)

Please select any of the following health conditions that *currently* apply to you:

☐ Asthma / Allergies	☐ High Blood Pressure	☐ Heart Conditions
☐ Diabetes	☐ Low Blood Pressure	☐ Liver / Kidney Disorders
☐ Arthritis	☐ High Cholesterol	☐ Osteoporosis
☐ Depression	☐ Cysts / Fibroids	☐ Fibromyalgia
☐ AIDS / STDS	☐ Cancer	☐ Chronic Fatigue Syndrome
☐ Other:		

5) Symptoms

Please select all the following symptoms that *currently* apply to you:

Skin:

- ☐ Acne
- ☐ Rash
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Unusually dry
- ☐ Itchy
- ☐ Color change
- ☐ Unusual perspiration
- ☐ Blisters
- ☐ Boils
- ☐ Abscess
- ☐ Warts / moles
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Head:

- ☐ Headache
- ☐ Migraine
- ☐ Head injury
- ☐ Concussion
- ☐ Hair loss
- ☐ Hair thinning
- ☐ Unusually dry hair
- ☐ Unusually oily hair
- ☐ Hair breakage
- ☐ Dandruff
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Nose / Sinuses:

- ☐ Congestion
- ☐ Runny nose
- ☐ Nosebleeds
- ☐ Seasonal allergies
- ☐ Sinus pressure
- ☐ Loss of smell
- ☐ Frequent colds
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Ears:

- ☐ Earache
- ☐ Hearing loss
- ☐ Excess ear wax
- ☐ Discharge
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Eyes:

- ☐ Dry / watery
- ☐ Itchy
- ☐ Blurry vision
- ☐ Strain
- ☐ Dark under eyelids
- ☐ Double vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Stye
- ☐ Clear discharge
- ☐ Pussy Discharge
- ☐ Pink eye
- ☐ Red / bloodshot eyes
- ☐ Yellow eyes
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Mouth / Throat:

- ☐ Sore throat
- ☐ Hoarse voice
- ☐ Loss of voice
- ☐ Difficulty swallowing
- ☐ Canker sore
- ☐ Cold sore
- ☐ Swollen gums
- ☐ Gum disease
- ☐ Sensitive gums
- ☐ Sensitive teeth
- ☐ Toothache
- ☐ Dentures
- ☐ Loss of taste
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Neck:

- ☐ Stiffness
- ☐ Swollen glands
- ☐ Sore movement
- ☐ Tight muscles
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Respiratory:

- ☐ Persistent Cough
- ☐ Wet cough
- ☐ Dry cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Wheezing
- ☐ Painful breathing
- ☐ Asthma
- ☐ Chest pain
- ☐ Shortness of breath (with exertion)
- ☐ Shortness of breath (when sitting)
- ☐ Shortness of breath (when lying down)
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Cardiovascular:

- ☐ High blood pressure
- ☐ Chest pain
- ☐ Palpitations
- ☐ Uneven heartbeat
- ☐ Low blood pressure
- ☐ Murmurs
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Gastro / Urinary:

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Gas
- ☐ Indigestion
- ☐ Heartburn / acid reflux
- ☐ Change in appetite
- ☐ Ulcer
- ☐ Hemorrhoids
- ☐ Discharge / blood
- ☐ Gallstones
- ☐ Kidney stones
- ☐ Painful urination
- ☐ Painful bowl movements
- ☐ Blood in urine
- ☐ Blood in stools
- ☐ Upset stomach
- ☐ Rumble sounds in belly
- ☐ Urine color is dark brown
- ☐ Urine color is clear or pale yellow
- ☐ Urine color is dark yellow or orange
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Arms / Legs:

- ☐ Swollen ankles
- ☐ Swollen wrists
- ☐ Varicose veins
- ☐ Edema (water retention)
- ☐ Leg cramps
- ☐ Restless leg syndrome
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Joints and Muscles:

- ☐ Weakness
- ☐ Stiffness
- ☐ Tremors
- ☐ Arthritis
- ☐ Joint pain
- ☐ Muscle spasms
- ☐ Muscle cramps
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Nervous System:

- ☐ Paralysis
- ☐ Numbness
- ☐ Tingling sensations
- ☐ Seizures
- ☐ Carpal tunnel
- ☐ Fainting
- ☐ Back pain that shoots down to the legs
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

Female Health:

- ☐ Menstrual pain
- ☐ Heavy menstrual bleeding
- ☐ Menstrual cramps
- ☐ Non-menstrual cramps
- ☐ Irregular periods
- ☐ Dry vagina
- ☐ Unusual vaginal discharge
- ☐ Vaginal thrush
- ☐ Candida
- ☐ Vaginal burning or itching
- ☐ Sores in vagina
- ☐ Decreased libido
- ☐ Pain with intercourse
- ☐ AIDS / STD
- ☐ Painful or sore breasts
- ☐ Cysts / Fibroids / Polyps
- ☐ Thyroid issues
- ☐ Adrenal fatigue
- ☐ Other:

If you checked any of the above symptoms, please give a brief description:

6) Habits & Lifestyle

On average, how many hours of sleep do you get at night?

Do you aim to go to bed around the same time each night, or do you go to bed "when you feel tired"?

Do you have any difficulty falling asleep or staying asleep?

Do you sleep soundly or is it a restless sleep?

Do you aim to wake up at the same time each morning or does it differ from morning to morning?

Do you wake up feeling rested?

Do you generally nap during the day?

On average, what is your daytime energy level? *(sluggish, moderate, high energy)*

In an average day, how much time do you spend outside?

How frequently do you exercise? *(daily, weekly, seldom)*

What form(s) of exercise do typically you do? *(walking, hiking, swimming, aerobics)*

How often do you get a day of rest?

When was the last time you took a vacation?

Are there any weather conditions that affect you?

Do you *regularly* come in contact with sick people?

How would you describe your level of germ consciousness?

On average, how much water do you drink everyday?

7) Diet & Nutrition

Are you currently on a restricted diet? If yes, please list the foods (or types of foods) you are able to eat:

What do you typically eat for breakfast?

On average, how much meat do you consume in a week?

On average, how much *fresh* fruit do you consume in a week?

On average, how many servings of *raw* vegetables do you consume in a week?

On average, how much "white flour" products do you consume in a week?

What type of bread do you usually eat (white, wheat, multi-grain, tortilla, pita, non-yeast breads, etc)?

About how much sugar do you consume in a week?

Do you use any sugar substitutes? If so, which ones?

How often do you eat out or order take-out food?

When shopping for groceries, do you typically go for the *cheapest* options or the *healthiest* options?

Where do you typically get your fruits and vegetables (grocery store, farmers market, garden, etc)?

How intentional are you about eating a well balanced, healthy diet?

How many times a week do you usually eat the following vegetables when they are in season:

* Potatoes	☐ Less than once a week or never	☐ Once a week or more
* Yams, sweet potatoes	☐ Less than once a week or never	☐ Once a week or more
* Broccoli or cauliflower	☐ Less than once a week or never	☐ Once a week or more
* Green beans	☐ Less than once a week or never	☐ Once a week or more
* Spinach, collard greens, kale	☐ Less than once a week or never	☐ Once a week or more
* Lettuce	☐ Less than once a week or never	☐ Once a week or more
* Cabbage or brussels sprouts	☐ Less than once a week or never	☐ Once a week or more
* Carrots	☐ Less than once a week or never	☐ Once a week or more
* Tomatoes	☐ Less than once a week or never	☐ Once a week or more
* Eggplant	☐ Less than once a week or never	☐ Once a week or more
* Plantains	☐ Less than once a week or never	☐ Once a week or more
* Pumpkin, zucchini, or squash	☐ Less than once a week or never	☐ Once a week or more
* Cucumbers	☐ Less than once a week or never	☐ Once a week or more
* Celery	☐ Less than once a week or never	☐ Once a week or more
* Bell Peppers	☐ Less than once a week or never	☐ Once a week or more
* Hot peppers (capsicum)	☐ Less than once a week or never	☐ Once a week or more
* Corn	☐ Less than once a week or never	☐ Once a week or more
* Peas	☐ Less than once a week or never	☐ Once a week or more
* Mushrooms	☐ Less than once a week or never	☐ Once a week or more
* Avocado	☐ Less than once a week or never	☐ Once a week or more
* Onions	☐ Less than once a week or never	☐ Once a week or more
* Garlic	☐ Less than once a week or never	☐ Once a week or more

Do you have any comments or insights you would like to share regarding the above?

How many times a week do you usually eat the following fruits when they are in season:

* Canned fruits, preserves, or cocktails	☐ Less than once a week or never	☐ Once a week or more
* Dried fruit	☐ Less than once a week or never	☐ Once a week or more
* Apples	☐ Less than once a week or never	☐ Once a week or more
* Bananas	☐ Less than once a week or never	☐ Once a week or more
* Oranges, mandarins, tangerines	☐ Less than once a week or never	☐ Once a week or more
* Grapefruit	☐ Less than once a week or never	☐ Once a week or more
* Lemons, limes	☐ Less than once a week or never	☐ Once a week or more
* Pears	☐ Less than once a week or never	☐ Once a week or more
* Peaches, nectarines, plums, apricots	☐ Less than once a week or never	☐ Once a week or more
* Grapes	☐ Less than once a week or never	☐ Once a week or more
* Cherries	☐ Less than once a week or never	☐ Once a week or more
* Berries (strawberry, blueberry, etc)	☐ Less than once a week or never	☐ Once a week or more
* Mangoes	☐ Less than once a week or never	☐ Once a week or more
* Papaya (paw-paw)	☐ Less than once a week or never	☐ Once a week or more
* Pineapple	☐ Less than once a week or never	☐ Once a week or more
* Guavas	☐ Less than once a week or never	☐ Once a week or more
* Melons (watermelon, cantaloupe, etc)	☐ Less than once a week or never	☐ Once a week or more

Do you have any comments or insights you would like to share regarding the above?

How many times a week do you usually eat the following foods:

* Eggs	☐ Less than once a week or never	☐ Once a week or more
* Milk	☐ Less than once a week or never	☐ Once a week or more
* Non-dairy milks (almond, soy, etc)	☐ Less than once a week or never	☐ Once a week or more
* Cheese	☐ Less than once a week or never	☐ Once a week or more
* Yogurt, kefir, cottage cheese	☐ Less than once a week or never	☐ Once a week or more
* Sauerkraut	☐ Less than once a week or never	☐ Once a week or more
* Pickles, olives, pickled foods	☐ Less than once a week or never	☐ Once a week or more
* Nuts (peanut, almond, etc)	☐ Less than once a week or never	☐ Once a week or more
* Soybeans, tofu	☐ Less than once a week or never	☐ Once a week or more
* Beans, lentils, split peas	☐ Less than once a week or never	☐ Once a week or more
* Peanut butter	☐ Less than once a week or never	☐ Once a week or more
* Seeds (pumpkin, sunflower, etc)	☐ Less than once a week or never	☐ Once a week or more
* Beef	☐ Less than once a week or never	☐ Once a week or more
* Chicken	☐ Less than once a week or never	☐ Once a week or more
* Pork	☐ Less than once a week or never	☐ Once a week or more
* Canned fish	☐ Less than once a week or never	☐ Once a week or more
* Fresh or frozen sea foods	☐ Less than once a week or never	☐ Once a week or more
* Rice	☐ Less than once a week or never	☐ Once a week or more
* Pasta, noodles	☐ Less than once a week or never	☐ Once a week or more
* Wheat	☐ Less than once a week or never	☐ Once a week or more
* Cous-cous, burghul, quinoa	☐ Less than once a week or never	☐ Once a week or more
* Oatmeal	☐ Less than once a week or never	☐ Once a week or more
* Muesli, granola, grain cereals	☐ Less than once a week or never	☐ Once a week or more

Do you have any comments or insights you would like to share regarding the above?

Please enter "yes", "no", or "in the past" regarding the use of each of the following:

Do you drink coffee (if "yes" or "in the past" how much or how often)?

Do you smoke, use tobacco or nicotine, or are frequently exposed to second-hand smoking (if "yes" or "in the past" how much or how often)?

Do you drink soda pop or energy drinks (if "yes" or "in the past" how much or how often)?

Do you drink *diet* soda or drinks that contain aspartame (if "yes" or "in the past" how much or how often)?

Have you ever used steroids (if "yes" or "in the past" how much or how often)?

Do you use antacids (if "yes" or "in the past" how much or how often)?

Do you use laxatives (if "yes" or "in the past" how much or how often)?

Do you regularly take pain medication (if "yes" or "in the past" how much or how often)?

Do you use sleeping pills (if "yes" or "in the past" how much or how often)?

Do you use antidepressants (if "yes" or "in the past" how much or how often)?

Do you struggle with any drug addictions?

Do you drink alcoholic beverages (if "yes" or "in the past" how much or how often)?

Do you struggle with alcohol addictions?

8) Health History

In general, how has your health been in the past?

As a child, were you generally strong and healthy or weak and sickly?

When you were born, were there any complications or anything unusual about the delivery?

In your very first weeks or months of life were you admitted to the hospital for any reason?

Can you think of any specific point in the past in which you noticed a “change” in the general condition of your health?

Have you ever had any operations or surgeries performed? If yes, please specify.

Have you ever had any broken bones or serious injuries? If yes, please specify.

Please list any vaccinations / immunizations you have had:

Are there any health conditions that run in your family?

Would you consider yourself “prone” to dental issues?

Have you ever had a root canal or major dental procedure performed?

Please select any of the following health conditions you have had in the past:

- ☐ Chicken Pox
- ☐ Hepatitis / Jaundice
- ☐ Gall/Kidney Stones
- ☐ Anemia
- ☐ Shingles
- ☐ Malaria
- ☐ Colitis
- ☐ Panic Attacks
- ☐ Measles
- ☐ Typhoid
- ☐ Ulcers
- ☐ Mental Illness
- ☐ Cysts / Fibroids
- ☐ TB
- ☐ Pneumonia
- ☐ Depression
- ☐ Cancer
- ☐ Heart Problems
- Other:

Do any of the above conditions still affect you today? If yes, please explain.

9) Stress Levels

In your own words, how would you describe what "stress" is?

In your opinion, how can you know if you are experiencing stress?

Can you describe the difference between "being under stress" and "*feeling* stressed"?

What would you say are the biggest stress factors in your life right now?

What would you say were your biggest stress factors at the time when you first started experiencing symptoms of your chronic illness?

How would you describe your current lifestyle? *(overwhelming, monotonous, relaxed, gratifying, etc)*

How would you describe the atmosphere in your home? *(happy, peaceful, high tension, lots of conflict, etc)*

Are you currently in a state of transition or change? If yes, are you finding it difficult to let go of the *"familiar"* and embrace the *"new"*?

What is your currently employment and how would you describe it?

Do you tend to over-extend yourself in commitments or find it difficult to say “no”?

Do you *often* find yourself feeling stressed or overwhelmed by all the work you need to do?

Do you tend to neglect your own needs for the sake of work or for the sake of others in your care?

Do you *often* find yourself pulling “all-nighters” and neglecting sleep in order to accomplish a task?

Are you hard on yourself when you fail to live up to the standards or expectations you set for yourself?

Do you *often* find yourself feeling stressed over seemingly little things?

How do you generally respond when feeling overly stressed or overwhelmed?

How do you work through the stress to regain peace?

Stress can accumulate over time, so it is important to take note of any major stresses or traumas in your lifetime. Think back over the years and list every *major* stress, traumatic event, or major adjustment that took place in each of the following categories:

Note: Stress does not always come from negative events but can also be brought on by very good and positive things in your life, such as getting married, having a child, getting a job promotion, going on a missions trip, visiting Disney World, etc. Even positive events can add extra stress to your life.

Childhood Trauma:

Social Challenges:

Stressful Relationships or Breakups:

Personality Conflicts:

Emotional Problems:

Depression or Mental Issues:

Accidents, Injuries, or Disabilities:

Major or Recurring Illnesses:

Loss of Family Members or Friends:

Personal Losses:

Job or Career Changes:

Moving or Relocating:

Financial Challenges:

Weighty Responsibilities:

Perfectionism or Unrealistic Expectations:

Heavy Workload

Major Life Changes:

Insecurities:

Traumatic Event:

Dangerous Situations:

Harassment or Violence:

Discrimination:

Environmental Stress:
(noise, pollution, crowds, poverty, natural disasters)

Other:

As you think through the events and challenges of the past, do you find any particular events that stand out in your mind as ones that you have not quite gotten over or worked through?

Which of the following de-stressing activities do you engage in on a *regular* basis?

- ☐ Walking / hiking / biking / running / jogging . . . *how frequently?*
- ☐ Swimming . . . *how frequently?*
- ☐ Aerobics or strenuous exercise . . . *how frequently?*
- ☐ Pilates exercise, yoga, or slow stretches . . . *how frequently?*
- ☐ Spending more than 10 minutes in concentrated prayer . . . *how frequently?*
- ☐ Reading or writing for pleasure . . . *how frequently?*
- ☐ Focusing on deep breathing . . . *how frequently?*
- ☐ Memorizing or meditating on Scripture . . . *how frequently?*
- ☐ Slowly sipping a hot drink . . . *how frequently?*
- ☐ Using aromatherapy or essential oils . . . *how frequently?*
- ☐ Listening to peaceful, uplifting music . . . *how frequently?*
- ☐ Sitting outside just listening to the sounds of nature . . . *how frequently?*
- ☐ Taking a nap . . . *how frequently?*
- ☐ Laughing out loud. . . *how frequently?*
- ☐ Getting a massage . . . *how frequently?*
- ☐ Taking a long, hot bath . . . *how frequently?*
- ☐ Singing out loud . . . *how frequently?*
- ☐ Joining in corporate prayer . . . *how frequently?*
- ☐ Working on a hobby, craft, or fun project . . . *how frequently?*
- ☐ Hugging or kissing your loved ones . . . *how frequently?*
- ☐ Listing things you are thankful for . . . *how frequently?*
- ☐ Fasting from electronics, internet, and social media . . . *how frequently?*
- ☐ Letting yourself have a good cry . . . *how frequently?*
- ☐ Surrounding yourself with the color green . . . *how frequently?*
- ☐ Reading a devotional or studying the Scriptures . . . *how frequently?*
- ☐ Having a long visit with a good friend . . . *how frequently?*
- ☐ Setting healthy boundaries for personal space / time . . . *how frequently?*
- ☐ Keeping a consistent daily routine . . . *how frequently?*
- ☐ Taking a whole day to rest and not do any work . . . *how frequently?*
- ☐ Getting at least 8 – 10 hours of sleep at night . . . *how frequently?*
- ☐ Other:

Which of the following symptoms of stress do you experience on a *regular* basis?

- ☐ Muscle strain or tension . . . *how frequently?*
- ☐ Headaches or migraines . . . *how frequently?*
- ☐ Panic attacks or pounding heart . . . *how frequently?*
- ☐ Tightness of chest . . . *how frequently?*
- ☐ Muscle spasms or cramps . . . *how frequently?*
- ☐ Change in sleep habits . . . *how frequently?*
- ☐ Constantly feeling tired or worn out . . . *how frequently?*
- ☐ Nausea or dizziness . . . *how frequently?*
- ☐ Grinding teeth . . . *how frequently?*
- ☐ Fidgeting . . . *how frequently?*
- ☐ Emotional mood swings . . . *how frequently?*
- ☐ Feeling overwhelmed . . . *how frequently?*
- ☐ Feeling agitated, constantly frustrated or easily angered . . . *how frequently?*
- ☐ Little or no patience with others . . . *how frequently?*
- ☐ Feeling like you can't overcome difficulties in your life . . . *how frequently?*
- ☐ Quick to cry about seemingly little things . . . *how frequently?*
- ☐ Thinking negatively or cynically . . . *how frequently?*
- ☐ Eating disorders (binge eating, loss of appetite, etc) . . . *how frequently?*
- ☐ Increased forgetfulness . . . *how frequently?*
- ☐ Feeling the need to always be busy . . . *how frequently?*
- ☐ Feeling guilty when you're not being productive . . . *how frequently?*
- ☐ Feeling the need or desire to withdraw . . . *how frequently?*
- ☐ Thinking of all the things you "should be doing" whenever you try to rest . . . *how frequently?*

- ☐ Other:

10) Spiritual Health

How would you describe your relationship with God?

How would you describe your prayer life?

How would you describe your experiences with corporate prayer?

How would you describe your spiritual growth in the last year?

Do you fast? If yes, how frequently?

Do you have a mentor or accountability partner?

What would you say is your life's calling or the thing you are most passionate about in life?

What are your areas of giftedness and how are you using them for the glory of God?

If you could change one thing in the world, what would it be?

Check the box next to any of the following that you particularly struggle with:

- ☐ Anger / hatred
- ☐ Lying
- ☐ Flattering others
- ☐ Slandering
- ☐ Cursing
- ☐ Critical nature
- ☐ Insensitive
- ☐ Jealousy
- ☐ Unforgiving
- ☐ Racial prejudice
- ☐ Materialistic
- ☐ Poor time management
- ☐ Binge eating
- ☐ Distance from God
- ☐ Pleasing people, not God
- ☐ Lust
- ☐ Pornography
- ☐ Worldly values
- ☐ Feeling unwanted
- ☐ Feeling hopeless
- ☐ Doubting your salvation
- ☐ Grumbling
- ☐ Telling half truths
- ☐ Manipulating others
- ☐ Criticizing
- ☐ Swearing
- ☐ Skeptical
- ☐ Self-centered
- ☐ Resentment
- ☐ Prideful
- ☐ Judging others
- ☐ Desire for gain
- ☐ Unwholesome chatter
- ☐ Abusive to your body
- ☐ Unteachable
- ☐ Worry (lack of trust)
- ☐ Mental adultery
- ☐ Fornication
- ☐ Feeling unloved
- ☐ Feeling disrespected
- ☐ Fear of God's will
- ☐ Fear of death
- ☐ Complaining
- ☐ Concealing information
- ☐ Gossiping
- ☐ Speaking falsely about someone
- ☐ Being cynical
- ☐ Negative thinking
- ☐ Begrudging
- ☐ Ungratefulness
- ☐ Stubborn / Insistent
- ☐ Looking down on others
- ☐ Desiring evil
- ☐ Lack of self-control
- ☐ Devalue of life
- ☐ Rebellious (resisting authority)
- ☐ Dread of failure
- ☐ Emotional affairs
- ☐ Homosexuality (or thoughts of)
- ☐ Feeling "not good enough"
- ☐ Fearful
- ☐ Doubting God's sovereignty
- ☐ Doubting God's goodness

Do you have any comments or insights you would like to share regarding the above?

Have you, or *anyone else* in your family ever . . .

Consulted a fortune teller or psychic?

Used an ouija board, crystal ball, tarot cards, or the like?

Engaged in astrology readings or consultations?

Read horoscopes or the like?

Had their palm read?

Been involved in Wicca or magical arts?

Used white magic?

Consulted the dead?

Been involved in a cult?

Been involved in casting spells or working charms?

Frequently read books that focus primarily on witches, sorcerers and magic?

Engage in New Age practices (including some forms of Yoga)?

Worshiped in a temple?

Practiced a religion that acknowledged other gods or spirits other than the God of the Bible?

Prayed to any other god, spirit, or saint (including the Virgin Mary or St. Joseph)?

Buried any objects for the purpose of "protection" or "good fortune" (including the St. Joseph's statue)?

Used charms or any physical objects as a means of blessing, good fortune, or protection?

Struggle with addictions *(gambling, pornography, adultery, drugs, binge eating, video games, etc)*

Had an affair?

Intentionally had an abortion?

Assisted in Euthanasia?

Practiced homosexuality, beastiality, or engaged in sexual orgies?

Ended up in a mental ward?

Attempted suicide?

Do you recall anyone ever saying to you "go to hell", "curse you", or something similar?

Do you have any reason to suspect that someone has cursed you or desired evil to happen to you?

Do you have any comments or insights you would like to share regarding the previous list?

Are you aware of any sins you have committed that have not yet been confessed?

Do you have any sin that has been confessed but still comes to mind frequently or continues to haunt you?

Is there any thought or action that you wish you could be free of for good?

Do you have any habits or addictions that you wish you could gain control over?

Do you have any experience(s) of seeing ghosts or spirits?

Do you see events or happenings in the spiritual realm?

11) Mental & Emotional Health

Describe your general attitude in the average day:

Would you consider yourself to be an optimist, pessimist, or realist?

Do you often find it difficult to sleep because of mental “chatter”?

Do you have frequent or recurring nightmares?

How do you deal with emotional tension? *(crying, yelling, talking it out, write about it)*

Do you find it difficult to express negative emotions?

How do you generally process negative emotions such as anger, fear, heartache, grief, etc?

Do you often find yourself having arguments or heated discussions circling around in your head?

Have you ever been diagnosed with a mental health condition?

Have you ever struggled with deep depression or thoughts of suicide?

Do you find yourself *often* thinking about death or dying?

How would you describe your relationship with your father?

Do you have any past grievances with your father that still come to mind today?

When you think of your father, are your first thoughts positive or negative?

How would you describe your relationship with your mother?

Do you have any past grievances with your mother that still come to mind today?

When you think of your mother, are your first thoughts positive or negative?

How would you describe your relationship with your siblings?

Do you struggle with having negative thoughts towards any of your siblings?

Have you been in any stressful, abusive, or hurtful relationships in the past?

What would you say was the most hurtful experience you had in a relationship?

Are there any people in your life (at work, church, home, community, etc) who you regularly find yourself in conflict with?

Are there any people in your life who you find yourself trying to avoid?

Are you holding a grudge against anyone, or have any past offenses that have not yet been resolved?

Have you ever been a victim of physical abuse?

Are you angry at yourself for any reason or have anything specific that you have a hard time forgiving yourself for?

Our body produces chemicals in response to the emotions we feel. These chemicals play a *huge* role in influencing the health of our bodies, either for good or for bad. Negative emotions have great potential to harm our bodies and lead to serious and chronic illnesses.

Work through the list below and check any that *describes* you, or any that you find you *struggle* with or experience *frequently*:

- ☐ Boredom
- ☐ Sadness
- ☐ Low confidence
- ☐ Disappointment
- ☐ Guilt
- ☐ Regret
- ☐ Feeling like a failure
- ☐ Feeling condemned
- ☐ Judgmental of self
- ☐ Envious
- ☐ Anger
- ☐ Vindictive
- ☐ Abandoned
- ☐ Sorrow
- ☐ Hopeless
- ☐ Concern
- ☐ Isolation
- ☐ Humiliation
- ☐ Bitterness
- ☐ Stubborn
- ☐ Dishonest
- ☐ Prideful
- ☐ Brokenhearted
- ☐ Uneasiness
- ☐ Sense of deep loss
- ☐ Melancholy
- ☐ Self-pity
- ☐ Low self-esteem
- ☐ Dissatisfaction
- ☐ Frustration
- ☐ Shame
- ☐ Unfulfilled dreams
- ☐ Feeling judged
- ☐ Judgmental of others
- ☐ Unfulfilled longings
- ☐ Hate
- ☐ Rejection
- ☐ Betrayed
- ☐ Grief
- ☐ Anxiety
- ☐ Worry
- ☐ Unsupported
- ☐ Taken advantage of
- ☐ Grudging
- ☐ Insistent
- ☐ Competitive
- ☐ Vain
- ☐ Disgusted
- ☐ Doubtful
- ☐ Feeling undesirable
- ☐ Indifference
- ☐ Depression
- ☐ Feeling “not good enough”
- ☐ Self-dislike or self-hatred
- ☐ Irritation
- ☐ Remorse
- ☐ Unmet expectations
- ☐ Insecure
- ☐ Jealous
- ☐ Resentment
- ☐ Malice
- ☐ Contempt
- ☐ Alone
- ☐ Loneliness
- ☐ Fear
- ☐ Fright
- ☐ Unhappiness
- ☐ Unappreciated
- ☐ Unforgiving
- ☐ Deceptive
- ☐ Rivalrous
- ☐ Apprehensive
- ☐ Distrusting
- ☐ Broken dreams
- ☐ Needy or dependent
- ☐ Feeling “trapped” or like your life is out of your control
- ☐ Feeling stuck or held back
- ☐ Feeling the need to put up a strong front for the sake of others.
- ☐ Overwhelmed by responsibility

Do you have any comments or insights you would like to share regarding the previous list?

12) Fear & Anxiety

Do you often find yourself fearful or anxious?

Do you often find yourself distressed or anxious, but are unable to identify exactly what it is you fear?

Do you have any recurring fears or phobias? Please list as many as you can think of:

Do you ever experience panic attacks? If yes, how frequently?

Do you ever find yourself shaking or trembling for no apparent reason?

Are you easily startled, alarmed, or surprised?

Do you find your mind imagining frightening or alarming scenarios?

Do you ever feel fearful that there may be someone “lurking” in the dark?

Have you experienced any traumatic events in the past which come to mind periodically or cause flashbacks?

Do you ever find yourself fearful about the future or about potential problems that *could* happen someday?

Do you have vague fears which you cannot explain?

Do you have specific fears you can identify and wish you could overcome?

Do you ever NOT do something because you are afraid of failure?

Are you fearful that something might happen to someone close to you?

Does your “over-concern” or worry for others cause you considerable distress?

Do you ever fear losing control of your mind or body?

Do you ever fear losing control and hurting yourself or others?

Have you recently been troubled by nightmares?

Do you every wake up feeling startled or afraid but cannot identify any reason?

13) For Women Only

Are you in premenopause, menopause, or postmenopause?

Start date of last menstrual cycle:

Do you have any irregularity in your periods? If yes, please explain.

Do you experience any problems with PMS or menopause? If yes, please explain.

Did you have any health problems or development delays when going through puberty?

Have you ever struggled with infertility?

Have you ever used birth control pills or an IUD?

Are you currently using any birth control methods?

Are you currently pregnant? If yes, how many weeks?

Are you currently breastfeeding? If so, how old is your child?

Have you had any miscarriages, stillbirths, or abortions?
(If yes, please share specifics, especially how far along you were in the pregnancy, how long ago it was, and whether or not you got pregnant again after the experience.)

Have you had any complications in any of your pregnancies?

How many successful births have you had?

Have you had any cesarean sections or birth complications?

Have you ever had your hormones tested? How long ago and what were the results?

Have you ever undergone hormone replacement therapy?

Have you ever had a pelvic exam or ultrasound to examine the vagina, cervix, and uterine condition?

Have you had a hysterectomy, mastectomy, or any operation of the breast or sexual organs?

Have you ever had a mammogram? If yes, how many or how frequently?

Do you have any “female” problems that you seem particularly prone to?

Did you feel nurtured or “well informed” when you went through puberty?

Did you feel nurtured, mentored, or “well informed” when you first learned about sex?

Do you have any female friends who pour into your life or minister to you?

Do you have any female person (either related or non-related) that makes you feel to some degree like you are “competing” with her or in some way a “rival” to her? *(It could be your mother, mother-in-law, sister, aunt, grandmother, daughter, co-worker, neighbor, acquaintance, etc).*

Are you currently under the headship, authority, and protection of a male figure?

14) For Married Persons Only

How many years have you been married?

How would you describe the current state of your marriage?

How has your chronic illness affected your marriage relationship?

In your opinion, what are the roles of husband and wife? And how does your marriage measure up to these expectations?

Who, would you say, wears the “pants” in the house?

Who would you say is the “spiritual leader” in your home?

What would you say are the *three* biggest challenges your marriage has faced over the years?

Is there a lot of conflict or tension in your relationship?

How do you and your spouse deal with conflict?

How well do you and your spouse communicate with one another?

What would you say are the areas of *strength* in your relationship?

What would you say are the areas of *weakness* in your relationship?

In the last week, has your attitude towards your spouse been primarily positive or negative?

How often do you and your spouse pray together?

How often do you spend concentrated time in prayer for your spouse?

When was the last time you shared a good laugh with your spouse?

In the last week, have you felt loved and cherished?

In the last week, have you felt valued and respected?

Do you generally feel appreciated by your spouse?

How would you describe your "love tank" right now? *(do you feel filled and satisfied, or empty and longing?)*

How would you describe the current level of quality time you have with your spouse?

How would you describe your current sex life or the quality of sex in your marriage?

Do you often experience a lot of tension or conflict in regards to sexual intimacy?

Do you struggle with feelings of insecurity or low self-esteem when it comes to sex?

Is there any part of your marriage or your relationship with your spouse that you feel discontented with or wish you could change?

What are the qualities in your spouse that you most admire and appreciate?

When you think about your spouse are your thoughts generally positive or negative?

15) Final Remarks

The space below is provided for you to include any further information or comments that you feel may be relevant to your current health condition, or helpful in understanding your health history:

16) Terms and Conditions

Please type your name in the space provided below and check the box if you agree to the given statement.

☐ I, ________________, understand that in submitting this form I am making an inquiry and seeking consultation in regards to the health condition(s) mentioned above. I understand that the recipient of this consultation form, Kelsey Weber, is not a medical doctor, but is a naturopath with a diploma in herbal medicine. I understand that only licensed doctors and practitioners can give a diagnosis or treatment to any medical conditions and that this is simply a consultation and will not result in a diagnosis or prescribed treatment.

I furthermore understand that I am taking full responsibility for my health. Any action I take as a result of this, or any following consultations, is done on my own accord. Kelsey Weber is in no way responsible for the outcome of any treatments I choose to take. I will in no ways hold others liable for the action I take in regards to my health.

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Please submit completed form by email to: kelsey@myallforjesus.com